General Assembly **Substitute Bill No. 5689**

February Session, 2008 *____HB05689INS__031308___*

AN ACT ALLOWING THE SALE OF GROUP SPECIFIED DISEASE POLICIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2009*) (a) As used in this section: (1) "Group specified disease policy" means a group policy delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2009, that pays benefits for the diagnosis or treatment of one or more specifically named diseases, illnesses, conditions or syndromes. Such policy may additionally provide benefits for any other condition or disease directly caused or aggravated by the specified disease, illness, condition, syndrome or its treatment; and (2) "preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a physician during the six months preceding the effective date of the coverage of the insured.

(b) No insurance company shall deliver or issue for delivery in this state any group specified disease policy that has an anticipated loss ratio of less than sixty-five per cent.

(c) Each group specified disease policy delivered or issued for delivery in this state shall meet the minimum benefit standards set forth in subdivision (1), (2) or (3) of this subsection:

(1) Coverage of medical expenses incurred by each individual insured under such policy, with a deductible not to exceed one thousand dollars, a coinsurance rate not to exceed twenty-five per cent and an aggregate lifetime benefit of not less than fifty thousand dollars;

(2) Per diem indemnification for each individual insured under such policy, with no deductible amount and an aggregate benefit limit of not less than fifty thousand dollars while medically confined, subject to the following minimum benefit standards: (A) A fixed-sum payment of not less than one hundred fifty dollars per day for each day of hospital confinement; (B) a fixed-sum payment of not less than one hundred dollars per day for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy; and (C) a fixed-sum payment of not less than fifty per cent of the hospital inpatient benefit per day for each day of nursing home care, hospice care or home health care for a minimum of one hundred days; or

(3) A fixed-sum payment, upon proof of diagnosis of the specified disease, illness, condition or syndrome, of not less than ten thousand dollars, except that such payment amount may be limited to not less than two thousand five hundred dollars for one or more specified covered diseases, illnesses, conditions or syndromes where coverage under such policy is provided for two or more specified diseases, illnesses, conditions or syndromes. Coverage for a fixed-sum payment for a spouse or dependent of the insured may be made available to the insured, provided the benefit amount offered for such spouse or dependent shall not be less than twenty-five per cent of the benefit amount for the insured. Where coverage is advertised or otherwise represented to offer generic coverage of a specified disease, the same dollar amounts shall be payable regardless of the particular subtype of the disease, unless such subtype is clearly identifiable and the policy clearly differentiates such subtype and its benefits.

(d) A group specified disease policy that meets the minimum benefit standard requirements set forth in subdivision (1), (2) or (3) of

subsection (c) of this section may be approved for sale in this state with the inclusion of some, but not all, of the benefits otherwise permitted by another type of group specified disease policy. Such policy shall contain a conspicuous disclosure that it is a limited benefit policy that provides benefits of the stated policy type but does not contain the minimum benefits required to be provided by the state for a group specified disease policy of the other policy types. The following terms, as appropriate, shall be used to describe the policy types: "Medical expense reimbursement of a specified disease", "per diem indemnification of a specified disease" or "fixed sum payment for diagnosis of a specified disease".

(e) Each group specified disease policy delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2009, shall meet the following requirements:

(1) If payment is conditioned upon pathological diagnosis of a covered condition, such policy shall also provide that if a pathological diagnosis is medically inappropriate, a clinical diagnosis shall be accepted in lieu thereof;

(2) Include a renewal, continuation or nonrenewal provision, to appear on the first page of the policy and be appropriately captioned;

(3) Disclose any limitations with respect to preexisting conditions in a separate paragraph labeled "Preexisting Conditions Limitation". No policy shall impose a preexisting conditions provision that excludes coverage beyond twelve months following the insured's effective date of coverage;

(4) Contain a prominent statement on the first page of the policy in not less than fourteen-point bold face type as follows: "CAUTION! This is a limited policy. Read it carefully. It only pays benefits for (specified condition) treatment (or diagnosis).". The notice shall also appear on the first page of the certificate of coverage provided to the covered person;

(5) Include a thirty-day "free look" period. Notice of the "free look" period shall appear on the face page of the policy and on the first page of the certificate of coverage provided to the insured; and

(6) Benefits shall be paid regardless of other coverage.

(f) No group specified disease policy shall be delivered or issued for delivery in this state unless an outline of coverage is completed and is delivered with the policy or delivered to the applicant at the time application is made.

(g) Any application for a group specified disease policy shall contain a prominent statement above the signature of the applicant that a person who is already covered by Medicaid should not purchase this coverage. Such statement shall be in bold face type or contrasting color.

(h) A group specified disease policy may condition payment of benefits upon a covered person receiving medically necessary care or treatment or upon the diagnosis of a condition.

(i) The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the purposes of this section.

Sec. 2. Subsection (c) of section 38a-505 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

(c) The commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits under each of the following categories of coverage in individual policies, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy: Basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage and specified accident

coverage. Specified disease policies, riders and benefits shall be prohibited **[**whether issued**]** on **[**a group or**]** an individual basis, except as provided in section 38a-457, or as determined by the commissioner provided the commissioner, prior to permitting any sale of such policies, adopts regulations in accordance with chapter 54 to establish minimum standards for benefits in such specified disease policies, certificates, riders, endorsements and benefits.

Sec. 3. Subsection (c) of section 38a-554 of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

(c) The commissioner shall adopt regulations, in accordance with chapter 54, concerning coordination of benefits between the plan and other health insurance plans. No group or individual health insurance policy shall coordinate benefits or otherwise reduce benefit payments because a person is covered by, or receives benefits from, a group specified disease policy delivered, issued for delivery, renewed, amended or continued in this state.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2009*	New section
Sec. 2	*January 1, 2009*	38a-505(c)
Sec. 3	*January 1, 2009*	38a-554(c)

INS *Joint Favorable Subst.*